

**DEPARTMENT OF INSURANCE, FINANCIAL
INSTITUTIONS AND PROFESSIONAL REGISTRATION**

P.O. Box 690, Jefferson City, Mo. 65102-0690

In re:)
) Examination No. 0603-20-LAH
Premier Health Insurance Co., Inc. (NAIC #11529))

ORDER OF THE DIRECTOR

NOW, on this 13th day of May, 2009, Director John M. Huff, after consideration and review of the market conduct examination report of Premier Health Insurance Co., Inc. (NAIC #11529), (hereafter referred to as "Premier") report numbered 0603-20-LAH, prepared and submitted by the Division of Insurance Market Regulation pursuant to §374.205.3(3)(a), RSMo, and the Stipulation of Settlement and Voluntary Forfeiture ("Stipulation") does hereby adopt such report as filed. After consideration and review of the Stipulation, report, relevant workpapers, and any written submissions or rebuttals, the findings and conclusions of such report is deemed to be the Director's findings and conclusions accompanying this order pursuant to §374.205.3(4), RSMo.

This order, issued pursuant to §§374.205.3(4) and 374.280, RSMo and §374.046.15. RSMo (Cum. Supp. 2006), is in the public interest.

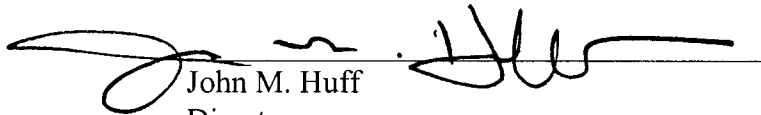
IT IS THEREFORE ORDERED that Premier and the Division of Insurance Market Regulation have agreed to the Stipulation and the Director does hereby approve and agree to the Stipulation.

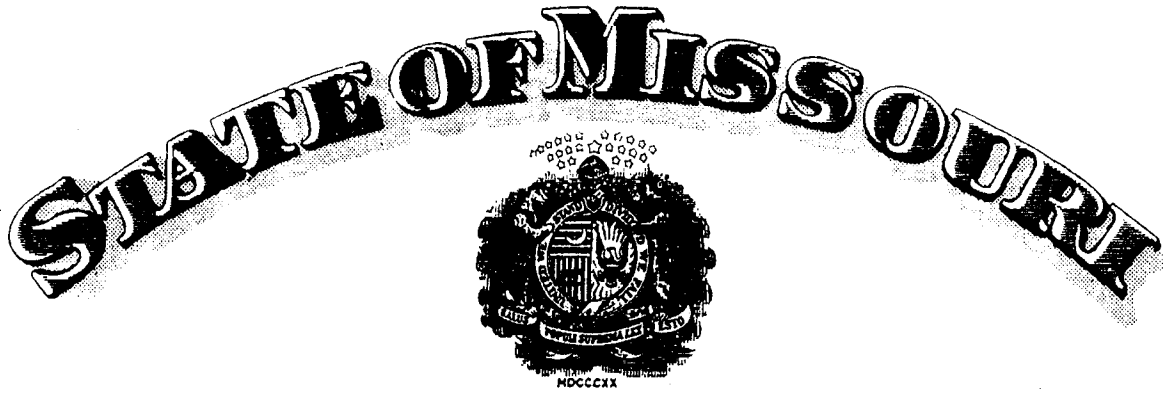
IT IS FURTHER ORDERED that Premier shall not engage in any of the violations of law and regulations set forth in the Stipulation and shall implement procedures to place Premier in full compliance with the requirements in the Stipulation and the statutes and regulations of the State of Missouri and to maintain those corrective actions at all times.

IT IS FURTHER ORDERED that Premier shall pay, and the Department of Insurance, Financial Institutions and Professional Registration, State of Missouri, shall accept, the Voluntary Forfeiture of \$36,072.81, payable to the Missouri State School Fund.

IT IS SO ORDERED.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of my office in Jefferson City, Missouri, this 13th day of MAY, 2009.


John M. Huff
Director



**DEPARTMENT OF INSURANCE, FINANCIAL
INSTITUTIONS AND PROFESSIONAL REGISTRATION**

P.O. Box 690, Jefferson City, Mo. 65102-0690

TO: Office of the President
Premier Health Insurance Co., Inc.
14528 South Outer Forty Rd., Suite. 300
Chesterfield, MO 63017-5705

RE: Premier Health Insurance Co., Inc. (NAIC #11529)
Missouri Market Conduct Examination #0603-20-LAH

**STIPULATION OF SETTLEMENT
AND VOLUNTARY FORFEITURE**

It is hereby stipulated and agreed by Douglas M. Ommen, Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration, hereinafter referred to as "Director," and Premier Health Insurance Co., Inc. (NAIC #11529), (hereafter referred to as "PHIC"), as follows:

WHEREAS, Douglas M. Ommen is the Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration (hereafter referred to as "the Department"), an agency of the State of Missouri, created and established for administering and enforcing all laws in relation to insurance companies doing business in the State in Missouri; and

WHEREAS, PHIC has been granted a certificate of authority to transact the business of insurance in the State of Missouri; and

WHEREAS, the Department conducted a Market Conduct Examination of PHIC and prepared report number 0603-20-LAH; and

WHEREAS, the report of the Market Conduct Examination has revealed that:

1. In some instances, PHIC allowed small employers to designate a workweek of more than 30 hours per week before they are considered eligible for health plan coverage, thereby violating the requirements of §§379.930.2(15) and 379.940.2, RSMo. See also DIFP Bulletin, #07-07.

2. In some instances, PHIC failed to acknowledge the receipt of grievances received in calendar years 2003 – 2005 in writing within 10 working days, in violation of §376.1382.2(1), RSMo.

3. In some instances, PHIC failed to set forth with specificity the reason for which additional time was needed for the investigation of grievances received in calendar years 2004 – 2005, in violation of §376.1382.2(2), RSMo.

4. In some instances, PHIC failed to notify the enrollee in writing of its decision within five working days after completing its investigation of the claims received in calendar year 2005, in violation of §376.1382.2(3), RSMo.

5. In some instances, PHIC failed to provide a denial reason on the EOB and RA of denied mammogram claims, in violation of §§375.1005(2), 375.1007(12), 376.383.9, and 376.384.2, RSMo.

6. In some instances, PHIC improperly denied Pap Smear claims they reviewed, in that it failed to effectuate prompt, fair and equitable settlement of the claims once liability had become reasonably, in violation of §§375.1007(4), and 376.383.5, RSMo.

7. In some instances, PHIC improperly investigated and denied ER claims, unreasonably delayed the investigation or payment of those claims, failed to communicate a sufficiently clear explanation of the reasons for denial or requests for additional information, failed to follow its own plan and claims' handling procedures, and paid claims more than 45 days after their initial receipt, in violation of §§375.1007(1), (3), (4), (6) and (11), 376.383.5 and .9, RSMo.

8. In some instances, PHIC failed to conduct a reasonable investigation prior to denying Modifier – 26 claims received and processed by its *Diamond* claims system, in violation of §375.1007(6), RSMo, and 20 CSR 100-1.010(1)(B) and (G).

9. In some instances, PHIC failed to maintain its books, records, documents, and other business records and to provide relevant materials, files, and documentation in such a way to allow the examiners to sufficiently ascertain the rating and underwriting and claims handling and payment, complaint handling, termination, and marketing practices of the Company, thereby violating §374.205.2(2), RSMo, and 20 CSR 300-2.200(2) and (3).

WHEREAS, PHIC hereby agrees to take remedial action bringing it into compliance with the statutes and regulations of Missouri and agrees to maintain those corrective actions at all times, including, but not limited to, taking the following actions:

1. PHIC agrees to take corrective action to assure that the errors noted in the above-referenced market conduct examination reports do not recur;

2. PHIC agrees to review all of its denied mammogram, Pap Smear, and ER claims submitted to the Company dated January 1, 2005, through May 1, 2008, to make a determination of liability. If the claim should have been paid, the Company agrees to issue any payments that are due to the claimants, bearing in mind that an additional payment of one per cent (1%) interest is also required on all electronically-submitted claims that were paid more than 45 days after receipt, per §376.384, RSMo, and at 9% on all paper claims pursuant to §408.020, RSMo, for any delayed payments from the date the claim was first received. A letter shall be included with the payments indicating that "as a result of a Missouri Market Conduct examination," it was found that additional payment were owed on the claim. Evidence shall also be provided to the Department that such payments have been made within 120 days after a final Order concluding this exam is entered by the Department; and

3. PHIC agrees to review all of its denied Modifier – 26 claims received through the *Diamond* and *Eagle* claims system dated January 1, 2005, through May 1, 2008, to make a determination of liability. If the claim should have been paid, the Company must issue any payments that are due to the claimants, bearing in mind that an additional payment of one per cent (1%) interest is also required on all electronically-submitted claims that were paid more than 45 days after receipt, per §376.384, RSMo. A letter should be included with the payments indicating that "as a result of a Missouri Market Conduct examination," it was found that additional payment was owed on the claim. Evidence should also be provided to the Department that such payments have been made within 120 days after a final Order concluding this exam is entered by the Department.

WHEREAS, PHIC neither admits nor denies the findings or violations set forth above and enumerated in the examination report; and

WHEREAS, PHIC is of the position that this Stipulation of Settlement and Voluntary Forfeiture is a compromise of disputed factual and legal allegations, and that payment of a forfeiture is merely to resolve the disputes and avoid litigation; and

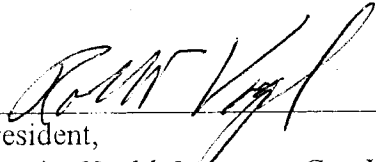
WHEREAS, PHIC, after being advised by legal counsel, does hereby voluntarily and knowingly waive any and all rights for procedural requirements, including notice and an opportunity for a hearing, which may have otherwise applied to the above referenced Market Conduct Examination; and

WHEREAS, PHIC hereby agrees to the imposition of the ORDER of the Director and as a result of Market Conduct Examination #0603-20-LAH further agrees, voluntarily and knowingly to surrender and forfeit the sum of \$36,072.81.

NOW. THEREFORE, in lieu of the institution by the Director of any action for the SUSPENSION or REVOCATION of the Certificate(s) of Authority of PHIC to transact the business of insurance in the State of Missouri or the imposition of other sanctions, PHIC does hereby voluntarily and knowingly waive all rights to any hearing, does consent to the ORDER of the Director and does surrender and forfeit the sum of \$36,072.81, such sum payable to the Missouri State School Fund, in accordance with §374.280, RSMo.

DATED:

April 7, 2007



President,
Premier Health Insurance Co., Inc.



April 25, 2008

Sent Via Federal Express

Ms. Carolyn H. Kerr
Senior Counsel, Market Conduct Section
Department of Insurance
Financial Institutions and Professional Registration
301 West High Street, Rm. 530
Jefferson City, MO 65102

RECEIVED
APR 28 2008
DEPT OF INSURANCE
FINANCIAL INSTITUTIONS
PROFESSIONAL REGISTRARS

Re: Missouri Market Conduct Examination #0603-20-LAH
Premier Health Insurance Co., Inc. (NAIC #11529)

Dear Ms. Kerr:

Enclosed are two hard copies and an electronic copy on CD of Premier Health Insurance Co., Inc.'s (renamed Mercy Health Plans) response to the DIFP Market Conduct Report.

If you have any questions, please feel free to contact me at (314) 214-8294.

Sincerely,

A handwritten signature in black ink, appearing to read "Charles S. Gilham", with a long horizontal flourish extending to the right.

Charles S. Gilham
Vice President, General Counsel

cms
enclosures

PREMIER HEALTH INSURANCE COMPANY,
INC. (NAIC 11529)
(RENAMED MERCY HEALTH PLANS)

RESPONSE TO

STATE OF MISSOURI

DEPARTMENT OF INSURANCE, FINANCIAL
INSTITUTIONS AND PROFESSIONAL
REGISTRATION

INSURANCE MARKET REGULATION DIVISION

EXAMINATION REPORT NUMBER
0603-20-LAH

SUBMITTED
APRIL 25, 2008

Premier Health Insurance Company, Inc. (renamed Mercy Health Plans) ("MHP"), hereby responds to the Department of Insurance, Financial Institutions and Professional Registration (DIFP) Market Conduct Examination Report Number 0603-20-LAH, with each numbered response corresponding to the issue presented in the "Examination Findings" section of the report, as follows:

I. Sales and Marketing

- A. Company Authorization – No issues noted by DIFP.
- B. Licensing of Producers and Producer Entities – No errors found.
- C. Marketing Practices – No errors found.

II. Underwriting and Rating Practices

- A. Forms and Filings – No errors found.
- B. Underwriting and Rating

The examiners stated that MHP was not offering coverage to all its eligible employees of a small employer because it allowed small employers to designate the required number of work hours for insurance eligibility, which the examiners stated could not exceed thirty (30) hours. For the reasons stated below, MHP disagreed with the interpretation by the examiners and does not feel that it should be penalized for the approach we had taken (but have subsequently abandoned, as indicated below):

The definition of "Eligible Employee" in Section 379.930.2(15) RSMo. reads as follows:

*(15) "Eligible employee" means an employee **who works on a full-time basis and has a normal work week of thirty or more hours.** The term includes a sole proprietor, a partner of a partnership, and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, **but does not include an employee who works on a part-time,** temporary or substitute basis. For purposes of sections 379.930 to 379.952, a person, his spouse and his minor children shall constitute only one eligible employee when they are employed by the same small employer; (bold and underline added).*

The DIFP examiners interpreted this section to mean that all employees of small employers who work 30 hours or more per week are entitled to coverage under the small employer's health plan. I believe that this is a narrow reading of the statute and that the statute is ambiguous and could be interpreted in other ways. The definition could have stated "works on a full-time basis with a normal work week of thirty or more hours", and such language would support the examiner's interpretation. However, the phrase "works on a full-time basis and has a normal work week of thirty or more hours" means that

there is a two-part analysis involved: (1) if the employee works on a full-time basis; and (2) if the employee has a normal work week of 30 or more hours. Both parts of this definition have to be satisfied in order to be considered an “eligible employee” under Section 379.930.2(15) RSMo.

The term “full-time basis” is not defined in the statute, nor is clarified by regulation. Without a specific definition, the determination and classification of what constitutes a full-time employee is left to the discretion of the employer. In general, 40 hours per week is usually considered to be “full time”, but common employment practices today (including shortened work weeks, flex time, etc.) has changed this perception. In fact, MHP’s parent company, Sisters of Mercy Health System, classifies anyone who works at least 36 hours per week as “full-time”. My point is that the classification of who is a full-time employee, and how many hours they have to work to attain that full-time status, is at the discretion of the employer.

Consequently, if a small employer classifies anyone who works for them as “full-time” if they work “x” number of hours (whether it is 30, 35, 40, etc.) then that is the standard that should be used to determine if they work on a “full-time basis” and are covered under the definition of “eligible employee”. Note that the statute states “30 or more hours per week” (which could be construed to mean a minimum of 35 hours) as opposed to “at *least* 30 hours per week” (which, if worded that way, would have clearly set the minimum hours at 30).

The statute could be construed to allow the employer to define how many hours an employee has to work to be considered “full-time”, but the statute would not allow the employer to “game the system” and classify a person who works only 10 or 15 hours a week as a “full-time” employee and be eligible for health coverage. This could be reason that the second part of the test of “eligible employee” is that the person has to work at least 30 hours per week.

Furthermore, the statute specifically *excludes* “an employee who works on a part-time . . . basis” from the definition of “eligible employee”. Thus, if an employer defines its full-time work force as employees who work 35 hours per week, anyone working less than that (including employees working 30 hours per week) would be considered to be part-time employees, and by definition are excluded from the statute.

Based on the above analysis, I respectfully disagree that MHP was in violation of Section 379.930.2(15) RSMo by allowing the employer to determine what constitutes a “full-time” employee, and any such full-time designation that exceeds 30 hours per week satisfies the definition of “eligible employee” under that statute for each of the groups listed.

Despite the fact that there is no definitive guidance to determine the meaning of “full-time basis” in the definition of “eligible employee” under Section 379.930.2(15) RSMo, MHP has been incorporating the 30 hour requirement since August, 2006. Consequently,

MHP is currently requiring all small employers to choose no more than 30 hours per week in the determination of who is eligible for the employer's health plan.

However, I would once again like to stress that MHP instituted this requirement despite the fact that there is no guidance to support the contention that the requirement is limited to 30 hours per week under the present wording of the statute, and there is no case law or regulation to support the more strict construction of the statutory requirements.

Based on the above, I do not believe that MHP should be penalized for its former interpretation of the phrase "thirty or more hours" in the definition of "eligible employee" contained in Section 379.930.2(15) RSMo.

III. Claim Practices

- A. Prompt Pay Health Benefit Plan Claims Practices – No errors found.
- B. Unfair Settlement and General Handling Practices – No errors found.

IV. Complaints

- A. Grievances and Appeals – No additional comments to findings in this section.
- B. Provider Grievances – No errors found.
- C. DIFP Complaints – No errors found.

V. Unclaimed Property

No errors found.

VI. Targeted Reviews

- A. PSA Denied Claims – No errors found.
- B. Mammogram Denied Claims – Errors found by the examiners were acknowledged and researched by MHP and found to be caused by a program configuration error. This error has been corrected, and the claims at issue were reprocessed and paid correctly. MHP appreciates the opportunity to improve upon its claims procedures based on the DIFP findings.
- C. Cancer Screening Denied Claims – No errors found.
- D. Pap Smear Denied Claims – Claims found by the examiners to have been processed incorrectly were reopened and paid correctly.

E. Denied ER Claims

- a. Claim paid \$20 as secondary carrier.
- b. No additional comment.
- c. The 3 claims at issue were reprocessed and paid during the examination.
- d. Ambulance claim reprocessed and paid during the examination; price rule corrected in system to allow the "QN" modifier.
- e. Evaluation and management (E&M) codes do not have a professional and technical component; therefore, it is *invalid* to bill with a "-26" modifier. CMS attachment A - Status Indicators, Surgical Service Indicator Table and Services Professional Component/Technical Component (PC/TC) document supports the codes listed for edit 004 in MHP's Auto Audit documentation to deny these E&M codes for inappropriate modifier. The codes are listed with a status indicator of 9, which indicates "*Concept of a professional/technical component does not apply.*" A copy of the PC/TC Indicator Table is attached.
- f. No additional comments.
- g. System error corrected; claim reprocessed and paid.
- h. Analyst error; claim reprocessed and paid.

F. Modifier 26 Denied Claims (Diamond)

(a) Although these claims involved Modifier 26, they were denied for other reasons. Following are some examples (not a complete list):

<u>#</u>	<u>Denial Reason (other than Modifier 26)</u>
35, 36	No authorization
40, 41	Duplicate claims
38	Timely Filing
33, 42, 43	No EOB
44, 45, 47	No EOB
32, 37, 39	AA030 (Separate procedure-payment included with major service)

Thus, although the examiners compiled a list of denied claim lines that included modifier 26, that may not have been the reason why the claim line was denied, and the assertion that "the company failed to conduct a reasonable investigation prior to denying the 193 claim lines" is not accurate.

(b) No additional response regarding these 3 claim lines.

(c) No additional response regarding these 12 claim lines.

G. Modifier 26 Denied Claims (Eagle)

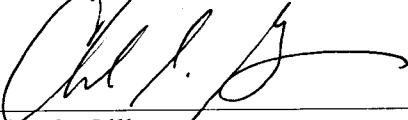
In reviewing MHP's responses to the examiners in preparation of this document, I learned that MHP does keep records of claims that enter the Eagle system (referred to in your report as "Eagle pre-processing records") but are summarily rejected by Eagle and never make it into

Diamond. Thus, we do have records in our claim files to show the handling and disposition of these claims, but for some reason were not able to produce that information to the examiners during the audit. I have enclosed a CD with the Eagle information, as the information is too voluminous to send in a hard copy. I understand that this probably will not make much difference to this criticism, as the information was not presented to the examiners during the audit, but I wanted to at least show that this information is retained by MHP in compliance with Section 375.1007(3) RSMo and 20 CSR 300-2.200(2)&(3) (B).

The reason that Eagle rejected these claims and did not send them into Diamond is that Eagle recognized that the claim had an inappropriate code (Modifier 26) attached to it, and this would be rejected in Diamond. In order to speed up the process of getting a correctly coded claim, Eagle sends the claim back to the provider (either on paper or electronically based on how it was received) to allow the provider to correct the coding on the claim and resubmit to MHP for payment. If these claims were to have gone on to Diamond, process as a claim, and then reject, the member would have received an EOB showing the denial, causing undue stress and concern. It is much faster and more "member friendly" to work in the background with the provider, send him the information quickly from Eagle that the claim needs to be revised for payment, and receive the information from the provider in order to reprocess and pay the claim. By handling it in this manner, the member does not know that the initial claim was denied as incorrect, which is a matter best left to work out between MHP and the provider.

- H. Modifier 26 Denied Claims (Eagle and Diamond)
See response to G above.
- I. Claims Paid More than 45 Days – Interest on the 2 claims at issue was under the \$5.00 minimum as contained in Section 376.383.5 RSMo.

Respectfully Submitted,



Charles S. Gilham

Vice President and General Counsel
Mercy Health Plans (formerly Premier Health Insurance Company, Inc.)

STATE OF MISSOURI

DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS AND
PROFESSIONAL REGISTRATION

INSURANCE MARKET REGULATION DIVISION

MARKET CONDUCT

EXAMINATION REPORT

OF THE

ACCIDENT AND HEALTH INSURANCE BUSINESS

OF

PREMIER HEALTH INSURANCE COMPANY, INC.

NAIC COMPANY CODE NUMBER: 11529

14528 South Outer 40, Suite 300

Chesterfield, MO 63017-5705

STATE OF DOMICILE: Missouri

September 26, 2007

REPORT NUMBER: 0603-20-LAH

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FOREWORD

This Market Conduct Examination Report is, in general, a report by exception. However, failure to comment on specific products, procedures, or files does not constitute approval thereof by the Missouri Department of Insurance, Financial Institutions and Professional Registration (DIFP). In performing this examination, the Missouri DIFP selected a small portion of the company's operations for its review. As such this report does not fully reflect a review of all practices and all activities of the company. The examiners, in writing this report, cited errors made by the company. The final examination report consists of three parts: the examiners' report, the company's response, and administrative actions based on the findings of Director of the DIFP.

Wherever used in the report:

“CMS” means Centers for Medicare and Medicaid Services;

“COB” means Coordination of Benefits;

“CPT” means Current Procedural Terminology;

“CSR” refers to Code of State Regulations;

“DIFP” refers to the Missouri Department of Insurance, Financial Institutions and Professional Registration;

“EOB” means Explanation Of Benefits;

“NAIC” refers to the National Association of Insurance Commissioners;

“NCCI” means National Correct Coding Initiatives;

“OIC” means Other Insurance Coverage;

“PHIC” or “the company” refers to Premier Health Insurance Company, Inc.;

“RA” means Remittance Advice;

“RSMo.” refers to the Revised Statutes of Missouri;

“TPA” means Third Party Administrator.

SCOPE OF THE EXAMINATION

The authority of the DIFP to perform this examination includes, but is not limited to, Sections 374.110, 374.190, 374.205, 375.445, 375.938, and 375.1009, RSMo. In addition, Section 447.572, RSMo grants authority to the DIFP to determine the company's compliance with the Uniform Disposition of Unclaimed Property Act.

The company reviewed was Premier Health Insurance Company, Inc.

The time period covered by this examination is primarily from January 1, 2005 through December 31, 2005, unless otherwise noted. The State of Missouri has not previously conducted a market conduct examination of this company.

The purpose of this examination is to determine whether the company complied with Missouri laws and with DIFP regulations. In addition, the examiners reviewed the company's operations to determine if they are consistent with the public interest.

While the examiners reported on the errors found in individual files, the examination also focused upon the general business practices of the company. The DIFP has adopted the error tolerance guidelines established by the NAIC. Unless otherwise noted, the examiners applied a 10 percent error tolerance ratio to all operations of the company with the exception of claims handling. The error tolerance ratio applied to non-health claims matters was seven percent. The error tolerance ratio applied to health claims was five percent. Any operation with an error ratio in excess of these criteria indicates a general business practice.

The examination included, but was not limited to, a review of the following lines of business: Accident and Health. The examination included, unless otherwise noted, a review of the following areas of the company's operations for the lines of business reviewed: Sales and Marketing, Underwriting and Rating, Claims, Complaints, and Unclaimed Property.

EXECUTIVE SUMMARY

This examination revealed the following principal areas of concern.

Market Conduct Examination:

- The company is not offering coverage to all of the eligible employees of a small employer, because it allows small employers to determine the number of hours worked per week for insurance eligibility. The company is not complying with Section 379.940.2.(5)(a), RSMo. In addition, the company's definition of "eligible employee" is not in compliance with Section 379.940.2.(5)(a), RSMo, because it requires "eligible employee" to work more than the 30 hours proscribed by Missouri law in Section 375.930.2(15), RSMo.
- The company, upon receipt of requests for 2003, 2004, and 2005 first level grievance review, failed to acknowledge receipt in writing of the grievance with 10 working days, and in some instances, failed to set forth with specificity the reason for which additional time was needed for investigation.

Targeted Reviews:

- The company admitted some "configuration errors" existed in certain denied 2005 mammogram claims, and some "analyst" and "system" errors also existed in some ER denied claims. The company fixed and paid these claim errors with interest after the examiners brought the errors to the company's attention.
- The company did not effectuate prompt, fair and equitable settlement of several 2005 pap smear denied claims.
- The company improperly denied certain 2005 ER claims because the requested information was not received. The company should have pended – rather than denied – these claims while an investigation was taking place or the company was waiting for further documentation.
- The company failed to follow its own procedures regarding Other Insurance Coverage (OIC) and Coordination of Benefits (COB).
- By denying ER claims with a Modifier 26 component for an improper reason, the company misrepresented to claimants and insureds relevant facts or policy provisions relating to coverages at issue and did not attempt in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear.
- The company failed to conduct a reasonable investigation prior to denying a large percentage of claims lines containing a Modifier 26 component and certain CPT codes.
- The company failed to pay interest due on several claims paid more than 45 days after receipt.

EXAMINATION FINDINGS

for

Premier Health Insurance Company, Inc.

NAIC COMPANY CODE NUMBER: 11529

I. SALES AND MARKETING

This section of the report details the examination findings regarding the company's compliance with the laws that monitor marketing practices. The items reviewed were the company's certificate of Authority for Missouri, licensing records pertaining to the company's sales personnel, and product marketing/advertising materials.

A. Company Authorization

Missouri law determines which company may sell insurance and the lines of insurance these companies may sell by requiring that each obtain the appropriate authority to transact the business of insurance. To protect the consumer, Missouri enacted laws and regulations to ensure that companies provide fair and equal treatment in its business dealings with Missouri citizens. An insurance company receives a Certificate of Authority that allows it to operate within the state only after it complies with certain application requirements regulated by the DIFP.

Premier Health Insurance Company, Inc., a Missouri corporation, has current authority to transact business in the following lines of insurance:

Life, Accident and Health Insurance

Premier Health Insurance Company, Inc. was found to be operating within the scope of its Certificate of Authority.

B. Licensing of Producers and Producer Entities

Missouri law requires the company to sell its insurance products through individuals and entities which the DIFP licenses. The Missouri licensing process intends to protect the public interest by requiring sales persons to pass examinations in order to qualify for a license. This process seeks to ensure that the prospective producer is competent and trustworthy.

The examiners found no errors during this review.

C. Marketing Practices

Missouri law requires that the company be truthful and provide full disclosure in the sale and promotion of its insurance products. The examiners reviewed the company's marketing and advertising materials, including training practices for producers, for the period January 1, 2003, through present.

The examiners noted no errors in this review.

II. UNDERWRITING AND RATING PRACTICES

In this section of the report, the examiners reviewed the company's underwriting and rating practices. These practices included the company's use of policy forms, adherence to underwriting guidelines, assessment of premiums, and procedures to decline or terminate coverage.

A. Forms and Filings

The examiners reviewed the company's policy forms to determine its compliance with filing, approval, and content requirements to ensure that the contract language is not ambiguous and is adequate to protect those insured.

The examiners noted no errors during this review.

B. Underwriting and Rating

Due to the small Missouri volume, the examiners reviewed only policies already issued by the company to determine the accuracy of rating and adherence to prescribed and acceptable underwriting criteria.

The following are the results of the review.

Small Employer Groups

Field Size:	245
Sample Size:	50
Type of Sample:	Random, Computer Generated
Number of Errors:	30
Error Rate:	60%
Within Department Guidelines:	No

The examiners found the following errors.

1. The following small employer group underwriting files contain PHIC Group Information renewal/new group forms completed by the employer that ask the employer to fill in the "# of hours worked per week for insurance eligibility". The employers completed the form by denoting that more than 30 hours were required, as listed below. *(NOTE: PHIC personnel then retype the small employer group handwritten information onto a clean Group Information form.)*

According to Section 379.930.2.(15), RSMo, in order to be eligible for coverage, employees in these small groups have to work on a full-time basis and have a normal work week of 30 hours or more.

PHIC is not offering coverage to all of the eligible employees of a small employer, because it allows small employers to require employees to work more than 30 hours per week before employees are eligible for coverage. The Missouri examiners found instances where employers required that employees work 32, 35, 36, 38, 40, or 40+ hours before an employee would qualify for coverage.

<u>Policy Number</u>	<u>Per Group Information Form, # of hrs worked/week for insurance eligibility</u>
PP1000951S	32
PP1002211S	35
PP1005511S	40
PP1006251S	35+
PP1008111S	40
PP1008911S	35
PP1017011S	40
PP1017411S	40
PP1017611S	40
PP1017911S	40
PP1018921S	40+
PP1020211S	40
PP1022111S	35
PP1025211S	35
PP1025511S	40
PP1026211S	40
PP1027411S	40
PP1028111S	40
PP1028911S	38
PP1031051S	40
PP1034621S	40
PP1036521S	36
PP1037521S	40
PP1037811S	40
PP1039111S	40
PP1039911S	40
PP1040211S	40
PP1046211S	36
PP1046311S	40
PP1050021S	40

2. In the PHIC Underwriting Manual Version: 1-2006, "Eligibility *Actively at Work Provision*" is defined as follows:

Employees must be *actively* at work for the minimum hours---30 hours or more---(or as determined by the employer's group application if greater than Mercy Health Plan required minimum of 30+ hours) to qualify for coverage an Initial Enrollment. Employees not actively at work on the effective date are not eligible to enroll, except employees on protected leave (i.e. FMLA etc)...

This PHIC definition is not in compliance with Section 379.940.2.(5)(a), RSMo., because it allows the employer's group application to require employees to work more than the 30 hours defined by Missouri law in Section 379.930.2.(15), RSMo to qualify as an "eligible employee."

While not agreeing with this Missouri DIFP Criticism, in its 8/14/2006 response to the DIFP Criticism, PHIC did state:

...in order to show that Premier is in good faith striving to be in compliance with the Auditor's [Missouri DIFP Market Conduct Examiners] interpretation of Missouri law, I [Charles S. Gilham, Vice-President and General Counsel] have instructed the actuarial staff to remove the contested provision from our Underwriting Manual and will begin to require all employees who work 30 hours per week or more for small employers to be offered coverage by the small employer....

References: Sections 379.930.2.(15) and 379.940.2.(5)(a), RSMo.

III. CLAIM PRACTICES

This section of the report details examination findings regarding PHIC's claims practices. The examiners reviewed such practices to determine whether claims submitted to PHIC are efficiently processed and accurately paid and for adherence to provisions of Missouri and DIFP regulations.

To minimize the duration of the examination, while still achieving an accurate evaluation of claim practices, the examiners reviewed a statistical sampling of the claims processed. A claim file, as a sampling unit, is defined as an individual demand or request for payment or action under an insurance contract. Benefits may or may not be payable under the contract when the request or demand is made.

The most appropriate statistic to measure compliance with Missouri law and DIFP regulations is the percentage of files found to be in error. A claim error includes, but is not limited to, any of the following:

- An unreasonable delay in the acknowledgement of a claim.
- An unreasonable delay in the investigation of a claim.
- An unreasonable delay in the payment or denial of a claim.
- A failure to calculate claim benefits correctly.
- A failure to comply with Missouri law regarding claim settlement practices.

A Prompt Pay Health Benefit Plan Claims Practices

Missouri prompt pay law has several requirements, including – but not limited to – the following: within 10 working days acknowledge receipt of a claim or request for additional information; payment/denial/request additional information within 15 days after receipt of additional information; payment of the claim or any undisputed part of the claim or deny or suspend the claim within 15 days after the day on which the health carrier or a third-party contractor received the additional requested information in response to a final request; and interest payment 45 days after company receipt of claim.

Paid-Denied Accident & Health (A&H) Claims

Field Size (# of claim transaction lines):	598,351
Sample Size (# of claim transaction lines):	100
Type of Sample:	Random, Computer Generated
Number of errors:	0
Error ratio:	0.0%
Within Department Guidelines:	Yes

In this review, the examiners noted no errors.

B. Unfair Settlement and General Handling Practices

The examiners reviewed paid and denied claims for adherence to claim handling requirements and contract provisions.

Paid & Denied A&H Claims

Field Size (# of claim transaction lines):	598,351
Sample Size (# of claim transaction lines):	100
Type of Sample:	Random, Computer Generated
Number of errors:	0
Error ratio:	0.0%
Within Department Guidelines:	Yes

In this review, the examiners noted no errors.

IV. COMPLAINTS

A. Grievances and Appeals

The examiners reviewed the company's handling of Grievances and Appeals from 2003, 2004, and 2005. The examiners noted the following exceptions in this review.

2003 First Level Grievances

Upon receipt of a request for first level grievance review on the following case, the company failed to acknowledge receipt in writing of the grievance within 10 working days.

<u>Grievance #</u>	<u>Member ID</u>	<u>Received</u>	<u>Acknowledged</u>	<u>Working Days</u>
G2611606SLC	496820227-01	12/30/2003	1/16/2004	12

Reference: Section 376.1382.2.(1), RSMo

2004 First Level Grievances

- a. Upon receipt of a request for first level grievance reviews on the following cases, the company failed to acknowledge receipt in writing of the grievances within 10 working days.

<u>Grievance #</u>	<u>Member ID</u>	<u>Received</u>	<u>Acknowledged</u>	<u>Working Days</u>
G3175136STLP+	M00597871	12/16/2004	1/6/2005	12
G2676470SLC	374786171-02	02/20/2004	3/23/2004	22

Reference: Section 376.1382.2.(1), RSMo.

- b. In its March 23, 2004, notice letter to the enrollee/member, the company failed to set forth with specificity the reason for which additional time was needed for the investigation of the following first level grievance.

<u>Grievance #</u>	<u>Member ID</u>	<u>Received</u>	<u>Date of Delay Letter</u>
G2676470SLC	374786171-02	2/20/2004	3/23/2004

Reference: Section 376.1382.2.(2), RSMo.

2005 First Level Grievances

- a. Upon receipt of a request for first level grievance review on the following case, the company failed to acknowledge receipt in writing of the grievance within 10 working days.

<u>Grievance #</u>	<u>Member ID</u>	<u>Received</u>	<u>Acknowledged</u>	<u>Working Days</u>
G3779714SPC	M00824531	11/08/2005	12/30/2005	34

Reference: Section 376.1382.2.(1), RSMo.

- b. In its October 25, 2005, notice letter to the enrollee/member, the company failed to set forth with specificity the reason for which additional time was needed for the investigation of the following first level grievance.

<u>Grievance #</u>	<u>Member ID</u>	<u>Received</u>	<u>Date of Delay Letter</u>
3714021 SLC	M00854073	10/12/2005	10/25/2005

Reference: Section 376.1382.2.(2), RSMo.

- c. The company failed to notify the enrollee in writing of its decision within five working days after completing an investigation of the following eight 2005 first level grievances.

<u>Grievance #</u>	<u>Member ID</u>	<u>Investig. Completed</u>	<u>Notification Letter Date</u>	<u>Working Days</u>
G3503367 SLC	M00747259	07/11/2005	07/20/2005	7
G3542187 SLC	M00834158	08/02/2005	08/12/2005	8
G3402602 SLC	M00755164	05/12/2005	05/25/2005	9
G3617671SLC	M00346396	09/08/2005	09/26/2005	12
G3235177 SLC	M00313730	02/08/2005	02/25/2005	13
G3696893 SLC	M00566125	10/26/2005	11/14/2005	13
G3242933 SLC	M00490717	02/10/2005	03/03/2005	15
G3539946SLC	M00443693	07/28/2005	08/19/2005	16

References: Sections 376.1382.2.(3) and 376.1350(14), RSMo.

B. Provider Grievances

The examiners reviewed the company's handling of Provider Grievances from 2004 and 2005. The examiners noted no errors.

C. DIFP Complaints

The examiners reviewed the company's handling of DIFP Complaints from 2003 through 2006.

In this review, the examiners noted no errors.

V. **UNCLAIMED PROPERTY**

The review included the company's procedures regarding unclaimed property.

The examiners found no errors.

VI. TARGETED REVIEWS

The DIFP used ACL to review specific types of denied claims data, focusing primarily on the following areas of concern: *PSA denied claims, Mammogram denied claims, Cancer screening denied claims, Pap Smear denied claims, and ER denied claims.*

The examiners also looked into the company's handling of certain claims using specific types of CPT code modifiers (-26).

In these targeted reviews, the Missouri examiners found the following errors.

A. **PSA Denied Claims**

Field Size (# of claim transaction lines):	56
Sample Size (# of claim transaction lines):	13
Type of Sample:	Systematic
Number of Errors:	0
Error Ratio:	0.0%
Within Department Guidelines:	Yes

In this review, the examiners noted no errors.

B. **Mammogram Denied Claims**

Field Size (# of claim transaction lines):	419
Sample Size (# of claim transaction lines):	28
Type of Sample:	Systematic
Number of Errors:	4
Error Ratio:	14.3%
Within Department Guidelines:	No

In this review, the examiners noted the following errors.

a. In reviewing the sample of denied mammography claims, the same provider submitted the following four claims:

<u>Claim #</u>	<u>DOS</u>	<u>Electronic or Paper Submitted Claim</u>
20050021587051	08/25/2005	Electronic
20050027919351	11/01/2005	Paper
20050028337051	11/03/2005	Paper
20050030412381	11/28/2005	Paper

Each of these claims had two lines with the following CPT codes: 76092 and 76092-26. The first line denoted the actual mammography screening and the second line denoted the professional component (*i.e., the physician's evaluation and management portion of the procedure*). This second segment was denoted by the standard CPT modifier "-26."

For the second portion of each of these above four claims, the company failed to provide a denial reason on the EOB and RA for these claims.

Since claim number 20050021587051 is an electronic claim with Date of Service (DOS) of 08/25/2005, it is subject to Sections 376.383.9. and 376.384.2., RSMo.

References: Section 376.383.9. and 376.384.2., RSMo.

The remaining three other paper claims are subject to Sections 375.1005(2) and 375.1007(12), RSMo.

As discussed during a 9/14/2006 meeting between the examiners and company personnel, the company determined the cause for the above missing denial reasons was a computer program "configuration error." This error resulted in the professional component of all such claims from that provider being denied without any reason given on the EOB/RA. The company reviewed and made additional payments on 20 similar claims during the course of this examination. The company also stated the computer program that resulted in these errors would be corrected.

References: Sections 375.1005(2) and 375.1007(12), RSMo.

C. Cancer Screening Denied Claims

Field Size (# of claim transaction lines):	71
Sample Size (# of claim transaction lines):	3
Type of Sample:	Systematic
Number of Errors:	0
Error Ratio:	0.0%
Within Department Guidelines:	Yes

In this review, the examiners noted no errors.

D. Pap Smear Denied Claims

Field Size (# of claim transaction lines):	115
Sample Size (# of claim transaction lines):	15
Type of Sample:	Systematic

Number of Errors:	6
Error Ratio:	40%
Within Department Guidelines:	No

In this review, the examiners noted the following errors.

Claim 20040029627421 -- The company denied this paper claim as the result of an analyst error by not recognizing receipt of an Explanation Of Benefits (EOB) from the member's primary carrier. The company did not effectuate prompt, fair and equitable settlement of this claim when liability had become reasonably clear.

<u>Claim Number</u>	<u>Date Rec'd</u>	<u>Date Paid</u>	<u>Days to Pmt.</u>
20040029627421	11/15/04	To be Determined	Over 703

Claim 20040030818361 -- The company denied this electronic claim because of confusion over which carrier was primary. The company's plan language concerning the order of benefit determination was improperly applied, and the claim was denied in error. The company did not effectuate prompt, fair and equitable settlement of this claim when liability had become reasonably clear. This claim was paid by the company during the course of the examination.

<u>Claim Number</u>	<u>Rec'd</u>	<u>46th Day</u>	<u>Date Paid</u>	<u>Int. Days</u>	<u>Amt. Paid</u>	<u>Interest Due</u>
20040030818361	12/04/04	01/19/05	09/26/06	616	\$32.30	\$6.54

Claim 20050008869401 -- The company denied this paper claim originally under claim number 0020040025370731 using reason code "NOELG." This claim was incurred on 09/07/04. File screen prints indicated the possibility that coverage was in force and may have continued through calendar year 2004. In response to Formal Request # 21, the company attached copies of a RA and check showing that this claim was reopened and paid as claim # 20040025370731 on 10/11/06. The company did not effectuate prompt, fair and equitable settlement of this claim when liability had become reasonably clear.

<u>Claim Number</u>	<u>Rec'd</u>	<u>Date Paid</u>	<u>Days to Pmt.</u>	<u>Amt. Pd.</u>	<u>Interest paid 10/17/06</u>
20050008869401 (paid under claim # 20040025370731)	04/11/05	10/11/06	548	\$22.10	\$3.66

Claims 20050022268081 and 20050022268111 -- The company denied these two electronic claims using reason code "NCPOS" -- "This service is not covered under the POS Rider." The company advised that the POS plan under which these claims were incurred has no POS rider. These claims were denied as the result of an analyst error and

will be reprocessed. Documentation of the reprocessing provided later to the examiners shows that the amounts payable on these two claims were applied to the member's deductibles. The company did not effectuate prompt, fair and equitable settlement of these claims when liability had become reasonably clear.

<u>Claim Number</u>	<u>46th day Received</u>	<u>After Rec'd</u>	<u>Claim Amt Allowed</u>	<u>Date Closed</u>	<u>Claim Outcome</u>
20050022268081	9/19/05	11/04/05	\$42.00	12/04/06	Applied to deductible
20050022268111	9/19/05	11/04/05	\$42.00	12/04/06	Applied to deductible

Claim 20050022073291 -- The company denied this electronic claim using reason code "XSERV" -- "This service/supply not covered by plan provisions." The company stated that this denial resulted from a configuration which was built into the system prior to 2001. The company stated that a total of six claims were denied due to this configuration error and that these six claims were reprocessed and paid during the course of the examination.

<u>Claim Number</u>	<u>Received</u>	<u>46th day After Rec'd</u>	<u>Claim Amt Allowed</u>	<u>Date Closed</u>	<u>Claim Outcome</u>
20050022073291	9/16/05	11/01/05	\$30.72	12/04/06	Claim Paid

Additional 5 claims to be paid and reported - details are to be determined and documentation will be provided to the Missouri Examiners.

References: Sections 375.1007(4) and 376.383.5., RSMo.

E. Denied ER Claims

Field Size (# of claim transaction lines):	925
Sample Size (# of claim transaction lines):	74
Type of Sample:	Systematic
Number of Errors:	11
Error Ratio:	14.9%
Within Department Guidelines:	No

In this review, the examiners noted the following errors.

- a. The following claim was improperly denied on the basis that information requested had not been received. The claim was received on 05/20/05, consisting of a hospital bill (UB92) and an EOB from Blue Cross/Blue Shield. The company requested other insurance information on 09/12/05, and subsequently denied the claim on 10/13/05, on the basis that requested information had not been received. Since the information the

company requested prior to denial of benefits was in the file when the claim was received, the company improperly denied this claim and unreasonably delayed processing.

It is an improper claims practice to unreasonably delay the investigation or payment of claims by requiring both a formal proof of loss form and subsequent verification that would result in duplication of information and verification appearing in the formal proof of loss form.

<u>Claim Number</u>	<u>EOB Code</u>	<u>EOB Date</u>	<u>Amount Billed</u>	<u>Amount Allowed</u>	<u>BC/BS Payment</u>
20050019763111	CLOSD	10/13/05	\$472.20	\$295.00	\$275.00

The company improperly denied benefits on this claim as noted above. The company approved payment of benefits, including interest as required by Missouri law during the course of this examination. Interest was allowed on the benefits payable beginning on the 46th day after receipt of the claim (05/20/05 plus 46 days = 07/05/05) until payment was made.

<u>Claim Number</u>	<u>Received</u>	<u>Amount Billed</u>	<u>Amount Allowed</u>	<u>BC/BS Payment</u>	<u>Net Claim Amount</u>
20050019763111	05/20/05	\$472.20	\$295.00	\$275.00	\$20.00

References: Sections 375.1007(11) and 376.383.5., RSMo.

- b. The following claim was denied, in part, because: "requested information not rec'd." This comment, coded "CLOSD," on the EOB is not clear, in that the comment does not specify the nature of the requested information. The company's EOBs did not communicate a sufficiently clear explanation so that the recipients would know exactly what information the company needed. Denial of a claim shall be communicated to the claimant and shall include the specific reason why the claim was denied.

Additional comments concerning each item are listed below. The company also failed to follow its own procedures since it did not request OIC information on these claims after the claims were submitted. The company's COB Procedure, Claim Rule 59, on page 3, reads, in part:

Note: Upon receipt of information of other insurance coverage for which a COBHS note is not present, proceed as follows:

1. Determine if the primary insurance can be determined

without additional information from the member.

- ...
3. If the primary insurance can not be determined:
 - a. Place the claim on hold with reason "OIC" (Pending for other insurance coverage information).
 - b. Enter a COBHS note, as follows:
 - 1) Complete the COBHS Header Screen (sequence 003) indicating it is unknown if MHP/PHP is primary, secondary, or tertiary, as indicated above.
 - 2) Complete the COBHS F4 note, as follows:
Description: OIC
Text: Pending
- c. *Send another insurance coverage questionnaire (P/11; MCR025/025.1)...* ***(emphasis added)***

Since neither claim, as submitted by the hospital, indicated the existence of any other insurance other than MHP/PHP (*i.e., this company*), it is clear that the identity of another primary carrier could not be determined without additional information from the member. Therefore, the company should have sent another insurance coverage questionnaire as noted above.

<u>Claim Number</u>	<u>EOB Code</u>	<u>Coverage Effective</u>	<u>Information Requested</u>	<u>Full-Time Student Status requested</u>
20050016008711	CLOSD	01/01/05	12/17/04	07/22/05

Reference: Section 376.383.9., RSMo.

- c. The following claims were denied in error because the company failed to follow the Midwest Associates (Core Plan) PHI-MO 8001 (08/02) plan certificate provisions under Section 7: Coordination of Benefits concerning "**C. Order of Benefit Determination Rules**", which states the following on page 34:
 - a. General. When there is a basis for a claim under this plan and another plan. This plan is a secondary plan which has its benefits determined after those of the other plan, unless:
 - (1) The other plan has rules coordinating its benefits with those of this plan; and
 - (2) Both those rules and this plan's rules, in subsection III.B., require that this plan's benefits be determined before those of the other plan.
 - b. Rules. This plan determines its order of benefits using

the first of the following rules which applies:

...

- (5) **Active or inactive employee.** The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule (5) is ignored.

According to the company's claim file records, the insured was a full time employee who last worked on 11/17/05. According to the CMS questions and answers on the www.cms.hhs.gov web site, Medicare can pay secondary to other plans when:

1. The individual or his/her spouse is currently employed/working and covered under an employer group health plan as a result of current employment.
2. The company has 20 or more employees or participates in a multiple-employer group health plan where at least one employer has 20 or more employees. . .

Therefore, PHIC's plan was primary to any coverage in effect with Medicare at the time these claims were incurred since the insured did not retire until 11/17/05.

There is no evidence at the time these claims were incurred that this insured had primary insurance through any other insurer. Therefore, the following claims should be reopened and paid as soon as possible. This position is based on the claim files originally provided to the examiners plus additional information provided by the company.

By denying these claims for improper reasons and by not following its own plan although it had all the information necessary to process and pay the claim as primary, the company misrepresented to claimants and insureds relevant facts or policy provisions relating to coverages at issue and did not attempt in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear.

<u>Claim Number</u>	<u>Incurred</u>	<u>Received</u>	<u>Denial Date</u>	<u>Amount Billed</u>
20050014923851	03/19/05	06/22/05	09/08/05	\$1,058.75
20050011224471	02/02/05	05/06/05	08/11/05	\$386.00
20050011224481	02/24/04	05/06/05	08/11/05	\$386.00

The company reprocessed these claims during the course of this examination. Claims 20050014923851 and 20050011224481 were paid, with interest and claim 20050011224471 was applied to the member's deductible.

References: Sections 375.1007(1) & (4), 376.383.5., RSMo.

- d. The company denied Claim 20050024023501 per the 11/09/05 EOB for "M78 Incomplete/invalid HCPCS modifier." The company's claim edit system denied the health care provider's use of the procedure code modifier "QN" on a bill for emergency ambulance services. Yet, procedure code modifier "QN" is acceptable for ambulance services according to the inside back cover of the ingenix 2006 Expert HCPCS Level II manual the company provided to the examiners. In its informal 9/7/2006 response to a examiner's inquiry about this claim, the company noted, "...The price rule should have been updated to accept the QN modifier from the provider..."

As a result of denying this claim for this improper reason, the company misrepresented to claimants and insureds relevant facts or policy provisions relating to coverages at issue and did not attempt in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear.

<u>Claim Number</u>	<u>Incurred</u>	<u>Received</u>	<u>Denial Date</u>	<u>Amount Billed</u>
20050024023501	09/22/05	10/10/05	11/09/05	\$880.00

After previously improperly denying payment of this claim as noted above, the company subsequently received a duplicate claim in March 2006 (Claim 2005002402350A). The re-filed claim did not have the "QN" modifiers previously submitted. The company paid the benefits due on 03/30/06. It was unclear from the claim file whether interest was paid on this claim as required by Missouri law when the claim was reprocessed. Since the claim was originally received on 10/10/05, interest should have been paid from 11/25/05 through 03/30/06 (*from the 46th day after receipt of the claim until payment, a total of 125 days*).

<u>Claim Number</u>	<u>Incurred</u>	<u>Received</u>	<u>46th Day After Rec'd</u>	<u>EOB Date</u>	<u>Amount Allowed</u>	<u>Interest Paid</u>
20050024023501	09/22/05	10/10/05	11/25/05	11/09/05	\$0.00	\$0.00
2005002402350A	09/22/05	03/03/06	11/25/05	03/30/06	\$514.80	\$21.16
					(\$89.95+\$424.85)	

The company paid the claim totaling \$514.80 plus \$21.16 interest.

The examiners asked the company to investigate if other claims were in error. The company's investigation report is that this claim was the only ambulance service claim denied using code M78 involving the HCPCS modifier "QN" during calendar year 2005. Also, the company's price rule has been corrected to allow the "QN" modifier as of 10/3/2006.

References: Sections 375.1007(1) & (4) and 376.383.5., RSMo.

- e. Regarding claim 20050013180361, the company's claim edit system denied the provider's use of the procedure code modifier "-26" on a bill for evaluation and management services. The EOB described this code as a "M78 Incomplete/invalid HCPCS modifier." The services billed were for professional services only. The "-26" modifier is used to identify the professional component of services provided to patients. Therefore, the "-26" modifier is neither incomplete nor invalid. The use of the modifier "-26" may be redundant, but its use should not be the basis for denial in this instance.

According to page 381 of Appendix A – Modifiers of the Ingenix 2006 CPT Expert manual which the company provided to the examiners, the "-26" CPT modifier for professional component concerns certain procedures that:

...are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier "-26" to the usual procedure number.

By denying this claim for an improper reason, the company misrepresented to claimants and insureds relevant facts or policy provisions relating to coverages at issue and did not attempt in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear.

<u>Claim Number</u>	<u>Incurred</u>	<u>Received</u>	<u>Denial Date</u>	<u>Amount Billed</u>
20050013180361	12/29/03	05/31/05	09/29/05	\$133.00

References: Sections 375.1007(1) & (4) RSMo

- f. Claim 20050005555861. The company denied this claim in error using reason code "AA030" - "Separate procedure-payment included with major svc." However, the claim which the company originally identified as the major service was CPT 90801 which was performed by a different physician than the one who billed for CPT 99283. Therefore, CPT 99283, billed under claim 20050005555861, should not have been included as part of CPT 90801 which was billed under claim 20050005555851.

The company, in its response to Formal Request # 17, stated that claim 20050005555861 was denied in error and has been reprocessed. The company, in reprocessing this claim, also paid interest as required by Section 376.383.5. RSMo, as noted below.

Also, in response to the original Criticism # 18 related to this matter, the company stated, in part:

...The two claims in question here were billed by two separate staff physicians using the same provider ID. Premier's system is set up to automatically deny these bills, because the majority of time this represents duplicate billing by the provider . . .

The company's response to original Criticism # 18, part (A), continued with the following statement:

...Consequently, because the provider did not contact Premier once they received the denial to provide correct information to us, there was no way for us to know that both claims should have been paid, and liability for the claim was **not** reasonably clear when the claim was received.

The company's procedures fail to consider the name of the provider recorded in Box 31 of a HCFA 1500 claim form as part of its screening process. The providers' names were submitted in this standard manner on both of these electronically submitted claims. It is not unusual for physicians in a group practice or hospital to share a provider ID number.

The HCFA 1500 forms submitted for claims 20050005555861 and 20050005555851 clearly identified that two different physicians provided distinct services. The company should have pended the second claim and investigated rather than automatically denying it as noted in the response to the original Criticism # 18. The company's standard practice was not to investigate conflicting information about the identities of

the attending physicians but to rely exclusively on providers to tell the company about the company's error. Therefore, the company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies.

Given that the company stated that it automatically denies these bills, the company failed to conduct a reasonable investigation relative to the identity of the physicians identified in Box 31 of the HCFA 1500 claim forms.

<u>Claim Number</u>	<u>Received</u>	46 th day- <u>Int. Paid</u> <u>From</u>	<u>Claim</u> <u>Paid on</u>	<u># Days Int.</u> <u>was Paid</u>	<u>Amount</u> <u>Allowed</u>	<u>Interest</u> <u>Paid</u>	<u>Total</u> <u>Paid</u>
2005000555861	03/08/05	08/06/05	10/04/06	529	\$64.89	\$11.29	\$76.18

References: Sections 375.1007(3) & (6) and 376.383.5. RSMo

- g. Claim 20050011193511. The company denied this electronic claim using reason code "M33" – "Incomplete/invalid UPIN of order/performing prov." This has been explained as being the result of a system error concerning an invalid provider record, and the company has advised that the record has been secured by the company to prevent future erroneous denials. This claim was paid more than 45 days after initial receipt by the company.

Claim 20050013949141. The company denied this electronic claim using reason code "M68" – Incomplete/invalid attending/referring phys. ID." This has been explained as being the result of an analyst error concerning the attending/referring physician ID, and not the result of a system error. This claim was paid more than 45 days after initial receipt by the company.

The company reprocessed these claims during the course of this examination and paid interest as required by Section 376.383.5.. RSMo.. as noted below.

<u>Claim Number</u>	<u>Claim</u> <u>Rcvd</u>	46 th day <u>After Rec'd</u>	<u>Claim Pd</u> <u>Amount</u>	<u>Date</u> <u>Paid</u>	<u>Days Int.</u> <u>Payable</u>	<u>Int. Paid</u> <u>10/13/06</u>
20050011193511	05/09/05	06/25/05	\$161.68	10/11/06	473	\$25.25
20050013949141	06/08/05	07/24/05	\$347.00	10/11/06	444	\$50.77

Reference: Section 376.383.5. RSMo

- h. Claim 20050011478811 -- The company denied this paper claim using reason code "M33" – "Incomplete/invalid UPIN of order/performing prov." This has been explained as being the result of an analyst error. This claim was paid during the course of this examination. 520 days after initial receipt by the company. The company did

not effectuate prompt, fair and equitable settlement of this claim when liability had become reasonably clear. *(Because this claim was not submitted electronically, interest is not payable under Section 376.383.5., RSMo.)*

<u>Claim Number</u>	<u>Received</u>	<u>Date Claim was Paid</u>	<u>Amount Paid</u>	<u>Days to Pay Claim</u>
20050011478811	05/09/05	10/11/06	\$449.91	520

Reference: Section 375.1007(4) RSMo

F. Modifier -26 Denied Claims (Diamond)

Field Size (# of claim transaction lines):	379
Sample Size (# of claim transaction lines):	379
Type of Sample:	Census
Number of Errors:	193
Error Ratio:	50.9%
Within Department Guidelines:	No

In this review, the examiners noted the following errors.

- a. DIFP performed a computer analysis resulting in a listing of 379 PHIC calendar year 2005 Diamond denied claim lines compiled from a larger listing PHIC provided to DIFP in November, 2006. The 379 claim lines contained CPT codes that include a modifier 26 denied during calendar year 2005. The DIFP compiled these 379 claim lines by sorting the CPT codes and researching relevant modifier 26 instances recognized by CMS that may contain a professional component in the CPT code. Based upon the examiners' review, it appears the company should have asked for additional information before it denied 193 of those 379 claim lines containing modifier 26. The DIFP compiled these 379 claim lines by sorting the CPT codes and researching relevant modifier 26 instances recognized by CMS that may contain a professional component in the CPT code.

The company failed to conduct a reasonable investigation prior to denying the following 193 claim lines.

<u>#</u>	<u>Claim Number</u>	<u>Line</u>	<u>Service Date</u>
1	20050016456441	003	07/05/05
2	20050032339091	005	10/13/05
3	20050011543041	006	04/29/05
4	20060004686511	001	09/26/05
5	20060004686511	002	09/29/05
6	20060004686761	002	09/22/05

<u>#</u>	<u>Claim Number</u>	<u>Line</u>	<u>Service Date</u>
7	20060004686761	001	09/14/05
8	20050031373741	003	12/16/05
9	20050028271131	001	10/10/05
10	20050005454461	001	02/02/05
11	20050008824431	002	03/19/05
12	20050003710071	001	01/20/05
13	20050012254801	001	04/29/05
14	20050018408151	002	07/12/05
15	20050016855501	001	05/06/05
16	20060009952981	001	11/14/05
17	20050016335081	001	06/13/05
18	20050020595031	004	08/17/05
19	20050008868831	001	03/20/05
20	20050013060981	001	05/01/05
21	20050025054601	001	08/27/05
22	20050025751381	001	10/11/05
23	20050027866901	002	08/30/05
24	20050028959581	010	10/10/05
25	20060001328331	004	11/22/05
26	20060002680101	001	12/16/05
27	20050027483181	001	10/28/05
28	20050025447971	001	10/09/05
29	20050025448221	001	10/08/05
30	20050028959581	008	10/10/05
31	20050029798291	003	09/18/05
32	20050019749951	002	08/02/05
33	20050023515521	002	08/20/05
34	20050022819281	002	08/08/05
35	20050018447861	001	07/12/05
36	20050031207141	001	12/05/05
37	20050020034791	001	07/24/05
38	20060022886781	001	03/15/05
39	20060010445291	004	05/26/05
40	20050006118601	001	03/03/05
41	20050007682591	001	02/24/05
42	20050005454641	002	02/02/05
43	20050008824431	001	03/19/05
44	20050005454641	003	02/02/05
45	20050009265731	001	02/27/05
46	20050014454301	001	03/15/05
47	20050017294661	001	06/22/05
48	20050010933271	001	04/18/05

<u>#</u>	<u>Claim Number</u>	<u>Line</u>	<u>Service Date</u>
49	20050012418871	001	05/15/05
50	20050018813291	001	07/23/05
51	20050020636531	002	07/23/05
52	20050016335081	002	06/13/05
53	20050020595031	001	08/17/05
54	20050030636861	001	11/29/05
55	20050011509971	001	04/30/05
56	20050016855501	005	05/06/05
57	20050017869991	001	07/18/05
58	20050019749951	001	08/02/05
59	20050023515481	001	08/10/05
60	20050023515521	001	08/20/05
61	20050022819281	001	08/08/05
62	20050018447861	002	07/12/05
63	20050021705721	001	08/25/05
64	20050007239011	003	03/15/05
65	20050011377041	002	04/30/05
66	20050025956611	001	10/10/05
67	20050016061381	001	05/11/05
68	20050016785541	004	07/01/05
69	20050020185081	002	08/05/05
70	20050020316081	002	08/19/05
71	20050027716561	004	11/09/05
72	20050028025381	002	11/04/05
73	20060000527201	003	12/30/05
74	20060003020041	004	12/09/05
75	20050007010791	004	02/25/05
76	20050007682591	002	02/25/05
77	20050004515461	002	02/14/05
78	20060009451181	002	12/29/05
79	20060013866511	002	12/29/05
80	20050026519811	002	10/25/05
81	20050026519811	002	10/25/05
82	20050018075831	001	07/07/05
83	20050021628601	002	07/19/05
84	20050031952791	001	11/29/05
85	20060001099381	001	12/28/05
86	20060007306241	001	08/26/05
87	20050021628601	001	07/19/05
88	20050002306681	002	01/10/05
89	20050002306841	002	01/13/05
90	20050002770431	002	01/13/05

<u>#</u>	<u>Claim Number</u>	<u>Line</u>	<u>Service Date</u>
91	20050023833541	001	09/07/05
92	20050031952801	001	11/29/05
93	20060005206241	002	09/02/05
94	20050021655961	001	02/19/05
95	20050021655961	001	02/19/05
96	20050002614181	001	01/15/05
97	20050022111141	003	08/16/05
98	20050032316061	002	11/16/05
99	20050022111141	001	08/16/05
100	20050002882031	001	01/27/05
101	20050014355321	002	05/25/05
102	20050014355321	002	05/25/05
103	20050019941641	002	08/03/05
104	20050010923511	002	03/24/05
105	20050019936671	002	07/29/05
106	20050002306681	001	01/10/05
107	20050002306841	001	01/13/05
108	20050002770431	001	01/13/05
109	20050032125151	001	11/30/05
110	20050023833541	002	09/07/05
111	20050030356161	001	11/17/05
112	20060005206241	001	09/02/05
113	20050021655961	002	02/19/05
114	20050021655961	002	02/19/05
115	20050002614181	002	01/15/05
116	20050021583711	002	08/24/05
117	20050021587051	002	08/25/05
118	20050021587061	002	08/25/05
119	20050022111141	004	08/16/05
120	20050023443871	002	08/23/05
121	20050025296601	002	09/20/05
122	20050027919351	002	11/01/05
123	20050028337041	002	11/03/05
124	20050028337051	002	11/03/05
125	20050030412381	002	11/28/05
126	20050032316061	001	11/16/05
127	20060000695441	002	12/20/05
128	20050022111141	002	08/16/05
129	20050027097051	001	10/15/05
130	20050031415251	002	10/09/05
131	20050016680061	001	06/17/05
132	20050005008551	003	02/23/05

<u>#</u>	<u>Claim Number</u>	<u>Line</u>	<u>Service Date</u>
133	20050019456631	003	07/27/05
134	20060000175591	001	09/20/05
135	20050027868691	001	08/08/05
136	20050023360181	001	09/06/05
137	20050015672641	001	06/15/05
138	20050011861601	001	05/05/05
139	20050031207181	001	12/09/05
140	20050017399151	001	06/13/05
141	20050031820601	001	12/08/05
142	20050030731271	001	10/06/05
143	20050029117291	001	08/24/05
144	20050019501811	001	08/04/05
145	20050020299681	001	08/12/05
146	20050027988581	001	11/03/05
147	20050029651991	001	11/15/05
148	20050030020751	002	09/26/05
149	20050030020751	002	09/26/05
150	20050023305241	004	09/13/05
151	20050007100491	001	03/18/05
152	20050016941771	004	01/07/05
153	20050020296721	001	08/15/05
154	20050020660241	001	04/15/05
155	20050025108391	002	09/29/05
156	20050030030331	001	11/22/05
157	20050030030331	002	11/22/05
158	20050031373741	001	12/16/05
159	20050019501811	002	08/04/05
160	20050020660241	002	04/15/05
161	20050027857041	001	09/19/05
162	20050027642251	001	11/02/05
163	20050015008741	001	06/06/05
164	20050003015181	001	02/03/05
165	20050007289211	001	03/15/05
166	20060000184571	003	12/09/05
167	20060000185421	004	12/15/05
168	20060000530671	004	12/27/05
169	20050027826171	001	11/02/05
170	20050028311591	002	11/08/05
171	20050007827111	003	03/03/05
172	20050020027431	003	04/08/05
173	20050027826171	003	11/02/05
174	20050028311591	006	11/08/05

<u>#</u>	<u>Claim Number</u>	<u>Line</u>	<u>Service Date</u>
175	20050031196241	006	12/06/05
176	20050007827111	004	03/03/05
177	20050020027431	004	04/08/05
178	20050027826171	002	11/02/05
179	20050028311591	005	11/08/05
180	20050031196241	005	12/06/05
181	20050007827111	005	03/03/05
182	20050020027431	005	04/08/05
183	20050027826171	005	11/02/05
184	20050028311591	004	11/08/05
185	20050031196241	004	12/06/05
186	20050007827111	006	03/03/05
187	20050020027431	006	04/08/05
188	20050027826171	004	11/02/05
189	20050028311591	003	11/08/05
190	20050031196241	003	12/06/05
191	20050007827111	007	03/03/05
192	20050002583265	001	03/17/05
193	20050030337461	001	11/03/05

References: Section 375.1007(6) RSMo, and 20 CSR 100-1.010(1)(B)&(G)

b. SUMMARY

The company has some errors in its claim adjudication system based on the below facts. As a result, the company failed to conduct a reasonable investigation before denying the following claims.

FACTS

In response to Formal Request # 28, the company stated that the following three claims were denied with reason code AA004 (*Inappropriate Use of Modifier*). These claims included charges for CPT 83735-26 (*Modifier 26 – Professional Component*). The company provided the examiners with a copy of its claim rule Edit 004 – Inappropriate Use of Modifiers from AUTO-AUDIT version 6.5 Clinical Manual, stating via a chart: “26 Professional Component Not Allowed with ... 83021 – 83909.”

The examiners’ investigation of these denials included the following:

- (1) (a) The CMS Web site describing Pathology and Laboratory Services includes National Correct Coding Initiative (NCCI) Edits for Physicians sorted by code ranges.

- (b) A search of the CPT codes for Pathology and Laboratory Services (Code Range 80000 – 89999) found no edits limiting the use of modifiers for CPT Code 83735, because CPT 83735 was not found anywhere on the limiting list.
- (2) The 2005 edition of the American Medical Association's (AMA) CPT Manual lists no limitations for CPT Code 83735.
- (3) The 2005 edition of the ingenix CPT Expert Manual lists no limitations for CPT Code 83735.
- (4) These claims were subsequently reprocessed with the reason: "XAA Auto Audit Exception."

In response to Formal Request # 28, the company provided a copy of a Mercy Health Plans Operations Policy # 001 relating to an "Administrative Allowance Policy." This policy allows for "courtesy" adjustments in certain circumstances. This policy applies only to processed claims. It does not apply to claims for services that have not yet been entered into the DIAMOND claims system. "Courtesy" adjustments include, but are not limited to, the following:

- Waiver of filing deadlines for claim payments for adjustments over one year old;
- Waiver of member deductible and/or copayment requirements when the amount was incorrectly stated by a MHP representative prior to receipt of service;
- Waiver of Plan exclusions/limitations when incorrectly stated by a MHP representative prior to receipt of service; and
- Waiver of Plan authorization requirements.

In response to Formal Request # 28, the company stated, in part:

The main reason an adjustment is made primarily surrounds two instances: either a provider is calling in and threatening to sue or send to collection his patient (our member) for failure to pay a claim (despite incorrect billing or some other problem with the claim outside of Premier's control), or a member is calling and has been threatened with collection by the provider due to an unpaid claim. In fact, several of the attached claims are from a provider that was repeatedly told he was billing incorrectly but refused to change his billing procedures. In order to keep his patient from collection, we processed the incorrectly billed claims...

ANALYSIS

- (5) The company repeatedly told the provider in this case that he was billing incorrectly, but PHIC did not consider whether or not its own claim edits were correct. While the company ultimately paid these claims under its Administrative Allowance Policy, it appears that the company edit used to deny these claims was incorrect. The original denials stated that the provider billed the claims with an "Inappropriate Use of Modifier." For these three claim lines, the primary basis for denial is not consistent with the CMS rules for NCCI. The actual CMS rules for NCCI do not list a rule for CPT 83735. The AMA and ingenix CPT Expert Manuals do not limit the use of modifiers for this CPT code. As such, the company failed to conduct a reasonable investigation prior to initially denying the following claim lines.

<u>Claim Number</u>	<u>Service Date</u>	<u>Amount</u>	<u>Units</u>	<u>Denied</u>	<u>Reprocessed</u>
20060002750711	12/19/2005	\$12.00	1	02/22/2006	05/11/2006
20060002750671	12/21/2005	\$24.00	2	02/22/2006	05/11/2006
20060002750691	12/22/2005	\$12.00	1	02/22/2006	05/11/2006

References: Section 375.1007(6) RSMo. and 20 CSR 100-1.010(1)(B)&(G)

c. SUMMARY

The company has some system errors in its claims adjudication system based on the below facts. As a result, the company failed to conduct a reasonable investigation before denying the following claims.

FACTS

In response to Formal Request # 28, the company stated that the following 12 claims were denied with reason code AA004 (*Inappropriate Use of Modifier*). These claims included charges for CPT 80048-26 (*Modifier 26 – Professional Component*). The company provided the examiners with a copy of its claim rule Edit 004 – Inappropriate Use of Modifiers from AUTO-AUDIT version 6.5 Clinical Manual, stating via a chart: "26 Professional Component Not Allowed with ... 80048 – 83018".

The examiners' investigation of these denials included the following:

- (1) The 2005 edition of the ingenix CPT Expert Manual includes two icons describing CPT Code 80048.

- (a) First, the boxed letter "A" is an Ambulatory Payment Classification (APC) Status Indicator which: "Indicates services that are paid under some other

method such as the DMEPOS fee schedule or the physician fee schedule.”
The CPT Expert Manual also states:

Status indicators identify how individual CPT codes are paid or not paid under the latest available hospital outpatient prospective payment system (OPPS). The same status indicator is assigned to all the codes within an Ambulatory Payment Classification (APC). Consult your payer or resource to learn which CPT codes fall within various APCs.

- (b) Second, another icon identifies Correct Coding Initiative (CCI) Comprehensive Codes as follows:

CPT Expert identifies those codes with a corresponding CCI edit in Version 10.3, effective October 1, 2004. The CCI edits define correct coding practices that now serve as the basis of the national Medicare policy for paying claims. The code noted is the column 1 (comprehensive) code.

- (2) The CMS web site describing Pathology and Laboratory Services includes NCCI Edits for Physicians sorted by code ranges. NCCI edits referenced are the same edits described in the Ingenix CPT Expert Manual noted above as CCI edits. A search of the CPT codes for Pathology and Laboratory Services (Code Range 80000 – 89999) found nine edits where CPT 80048 was listed under “Column 1.” For these edits, NCCI identifies Modifiers as code “1” meaning that Modifiers **are allowed**. In two cases, where CPT 80048 is under “Column 2”, the NCCI edits do not allow use of Modifiers when CPT 80048 is billed with CPT codes 80053 or 80069 (shown in column 1). None of the 12 claims listed below included charges for CPT 80053 or 80069.
- (3) These claims were subsequently reprocessed with the reason: “XAA Auto Audit Exception,” “XBEN Benefit Exception,” or “XLIA Member Liability Exception.”
- (4) In response to Formal Request # 28, the company provided a copy of a Mercy Health Plans (MHP) Operations Policy # 001 relating to an “Administrative Allowance Policy.” This policy allows for “courtesy” adjustments in certain circumstances. This policy applies only to processed claims. It does not apply to claims for services that have not yet been entered into the DIAMOND claims system. “Courtesy” adjustments include, but are not limited to, the following:
- Waiver of filing deadlines for claim payments for adjustments over one year old;
 - Waiver of member deductible and/or copayment requirements when the amount was incorrectly stated by a MHP

representative prior to receipt of service:

- Waiver of Plan exclusions/limitations when incorrectly stated by a MHP representative prior to receipt of service; and
- Waiver of Plan authorization requirements.

In response to Formal Request # 28, the company stated, in part:

The main reason an adjustment is made primarily surrounds two instances: either a provider is calling in and threatening to sue or send to collection his patient (our member) for failure to pay a claim (despite incorrect billing or some other problem with the claim outside of Premier's control), or a member is calling and has been threatened with collection by the provider due to an unpaid claim. In fact, several of the attached claims are from a provider that was repeatedly told he was billing incorrectly, but refused to change his billing procedures. In order to keep his patient from collection, we processed the incorrectly billed claims...

ANALYSIS

The company repeatedly told the provider in this case that he was billing incorrectly, but did not consider whether or not its own claim edits were correct. While the company ultimately paid these claims under its Administrative Allowance Policy, it appears that the company edit used to deny these claims was incorrect. The original denials stated that the provider billed the claims with an "Inappropriate Use of Modifier." For these 12 claim lines, the primary basis for denial is not consistent with the CMS rules for NCCI. The actual CMS rules for NCCI state in nine cases that Modifiers are allowed for CPT 80048 where this code is listed under column 1. Only two cases do not allow use of CPT Modifiers if CPT 80048 is billed with either CPT 80053 or 80069, where 80053 or 80069 is listed in column 1 and 80048 is listed in column 2. None of the claims listed below included charges for either CPT 80053 or CPT 80069. The ingenix edition of the 2005 CPT Expert Manual indicates that CPT 80048 is normally "...paid under some other method such as the DMEPOS fee schedule or the physician fee schedule." The ingenix edition of the 2005 CPT Expert Manual also indicates that CCI edits define correct coding practices for column 1 (comprehensive) codes.

The company failed to conduct a reasonable investigation to verify that its initial denials were based on rules consistent with ingenix CPT Expert Manual and CMS coding rules prior to denying the below claim lines.

<u>Claim Number</u>	<u>Service Date</u>	<u>Amount</u>	<u>Units</u>	<u>Denied</u>	<u>Reprocessed</u>
20060003751811	08/18/2005	\$52.00	1	02/16/2006	05/24/2006
20050013169261	01/19/2005	\$26.00	1	06/08/2005	07/15/2005
20050028150481	03/19/2005	\$14.00	1	11/23/2005	12/22/2005
20060002750741	12/19/2005	\$15.00	1	02/22/2006	05/11/2006
20060002750711	12/20/2005	\$15.00	1	02/22/2006	05/11/2006
20060002750671	12/21/2005	\$15.00	1	02/22/2006	05/11/2006
20060002750691	12/22/2005	\$15.00	1	02/22/2006	05/11/2006
20060002750691	12/23/2005	\$15.00	1	02/22/2006	05/11/2006
20060002750771	12/27/2005	\$15.00	1	03/02/2006	05/11/2006
20060002750641	12/29/2005	\$15.00	1	03/02/2006	05/11/2006
20060017586631	08/22/2005	\$26.00	1	06/21/2006	09/05/2006
20050003034061	01/02/2005	\$24.00	1	03/24/2005	04/20/2006

References: Section 375.1007(6) RSMo, and 20 CSR 100-1.010(1)(B)&(G)

G. Modifier –26 Denied Claims (Eagle)

Field Size (# of claim transaction lines):	55,646
Sample Size (# of claim transaction lines):	174
Type of Sample:	Systematic
Number of Errors:	Unknown
Error Ratio:	Unknown
Within Department Guidelines:	No

In this review, the examiners could not document any errors, because the company does not retain sufficient Eagle pre-processing records to prove an improper claims practice. The examiners consider Eagle pre-processing items to meet the Missouri definition of a valid claim. However, the company does not consider Eagle pre-processing items as claims unless they are “clean” and actually enter the company Diamond claims system. There were no more available records for the examiners to analyze.

The company did not maintain its claim files for the calendar year in which the claims were closed plus three (3) years. These claims were not maintained so as to show clearly the inception, handling, and disposition of each claim and were not sufficiently clear and specific so that pertinent events and dates of these events can be reconstructed.

References: Section 375.1007(3) RSMo, and 20 CSR 300-2.200(2)&(3)(B)

H. Modifier -26 Denied Claims (Eagle and Diamond)

Field Size (# of claim transaction lines):	56,025
Sample Size (# of claim transaction lines):	50
Type of Sample:	Systematic
Number of Errors:	Unknown
Error Ratio:	Unknown
Within Department Guidelines:	No

In this review, the examiners could not document any errors because the company does not retain sufficient Eagle pre-processing records to prove an improper claims practice. The examiners consider Eagle pre-processing items to meet the Missouri definition of a claim. Since the company does not consider Eagle pre-processing items as claims unless they are "clean" and actually enter the company Diamond claims system, there were no more available records for the examiners to analyze.

The company did not maintain its claim files for the calendar year in which the claims were closed plus three (3) years. These claims were not maintained so as to show clearly the inception, handling, and disposition of each claim and were not sufficiently clear and specific so that pertinent events and dates of these events can be reconstructed.

References: Section 375.1007(3) RSMo, and 20 CSR 300-2.200(2)&(3)(B)

I. Claims Paid More than 45 Days

Field Size (# of claim transaction lines):	58,341
Sample Size (# of claim transaction lines):	100
Type of Sample:	Computer generated random sample
Number of Errors:	2
Error Ratio:	2%
Within Department Guidelines:	Yes

In this review, the examiners noted the following errors.

The company paid the following claim line items more than 45 days after receipt. The company provided a list of claim line items for which interest was paid. However, these claims were not found on the list of interest payments. The amount of interest due on these claim line items is noted below. A health carrier may combine interest payments and make payment once the aggregate amount reaches five dollars.

<u>Claim Number</u>	<u>Received</u>	46 th day- <u>Interest beginning</u>	<u>Claim Paid on</u>	Line item = Days Int. <u>is Payable</u>	<u>Amount Allowed</u>	<u>Interest Payable</u>
20050017167931	07/20/05	09/04/05	09/07/05	4	\$1,040.00	\$1.37
20050018828561	07/21/05	09/05/05	09/15/05	11	\$151.58	\$0.55

The company was asked to review the other line items on the 8/10/2006 claims list provided to the examiners and verify in writing whether interest was paid on all the line items of each of these claims in accordance with Section 376.383.5., RSMo. For those items in which interest was not paid, a copy of the check and other documentation showing accurate interest payment was requested.

Reference: Section 376.383.5. RSMo

VII. CRITICISM AND FORMAL REQUEST TIME STUDY

This study is based upon the time required by the company to provide the examiners with the requested material or to respond to criticisms.

A. Criticism Time Study

<i>Calendar Days</i>	<i>Number of Criticisms</i>	<i>Percentage</i>
0 to 10	25	100.0%
> 10	0	0 %
Total: 25		100.0%

Eight extensions were requested and granted.

B. Formal Request Time Study

<i>Calendar Days</i>	<i>Number of Requests</i>	<i>Percentage</i>
0 to 10	28	100.0%
>10	0	0 %
Total: 28		100.0%

Two extensions were requested and granted.

VIII. EXAMINATION SUBMISSION

The examiners respectfully submit the examination report of Premier Health Insurance Company, Inc. to the Director of Insurance, Financial Institutions and Professional Registration, State of Missouri.

In addition to the undersigned, the following examiners participated in the examination.

Gary W. Kimball, CIE

Gary L. Land, CIE




James E. Mealer, CIE, Audit Manager

DATE: March 26, 2008

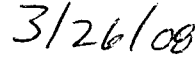
CHRISTINE VOLMERT
My Commission Expires
May 26, 2011
Cole County
Commission #07473638

SUPERVISION

The examination process has been monitored and supervised by the undersigned. The examination report and supporting work papers have been reviewed and approved. Compliance with NAIC procedures and guidelines as contained in the Market Regulation Handbook has been confirmed.



Michael W. Woolbright
Chief Market Conduct Examiner
Missouri Department of Insurance,
Financial Institutions and
Professional Regulation



Date